Introduction: Multiple surgical resections may be necessary in chronic Crohn's disease management. Laparoscopic techniques offer a minimally invasive approach. The 5-year experience of a Consultant Colorectal Surgeon in a District General Hospital is described. Short-term outcomes of elective laparoscopic procedures are emphasized.
Methods: Patient and operative data were extracted from a prospective database for the period November 2007 to November 2011.
Results: 14 elective laparoscopic procedures were performed on 13 patients (7 male, 6 female) with Crohn's disease. Median age was 42.8 years (range 17.3-68.9 years). The procedures comprised: 11 right-hemicolectomies, 1 sigmoid-colectomy and 2 ileostomy reversals. 5 were repeat resections for recurrent disease at the ileo-colic junction. Prior ileo-colic resection had occurred in 4 patients, (6 prior resections in 1 patient, 3 in 1 patient and 2 in 2 patients). Open conversion occurred in 1 patient, who had undergone a prior resection. One anastomotic leak (1/14, 7.1%) occurred, following primary right-hemicolectomy. Median length of stay in the resection group was 6.5 days (range 2–11 days). No post-operative deaths occurred.
Conclusion: Laparoscopic techniques may be routinely applied to the surgical management of Crohn's disease; this includes patients requiring repeated resections in chronic disease, without significant additional morbidity.

0496: AUDIT OF LYMPH NODE HARVEST DURING BOWEL RESECTION FOR COLORECTAL CANCER

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Aims: To perform an audit of lymph node (LN) harvest, an independent prognostic factor for 5 year survival, during colorectal resections. The National Bowel Cancer Audit in 2010 identified that the median number of LNs excised with the specimen should be15 for colonic cancer and 13 for rectal cancer.
Methods: Retrospective analysis of prospectively collected data was performed of all eligible patients between January 2010 and August 2011 (20 months).
Results: A total of 177 patients were diagnosed with colorectal cancer during this study period. 72 patients were excluded for a variety of reasons, but predominantly for metastatic disease (47). Results from 105 patients are reported. 93 patients had colon cancer resections. 55 (59.1%) of these patients had more than 15 LNs excised with the specimen. LNs were positive in 43 (46.2%). 12 patients underwent surgery for rectal cancer. 9 (75%) of these patients had 13 or more lymph nodes excised with the specimen. LNs were positive in 4(33.3%).
Conclusions: In a majority, the LN yield following colorectal resection at our centre was above the National average for rectal and colonic cancers in this study period, but the surgical technique needs to improve for colonic resections and a re-audit performed.

0540: LARGE BOWEL OBSTRUCTION CAN BE SAFELY TREATED BY COLONIC STENT INSERTION - CASE SERIES FROM A UK DISTRICT GENERAL HOSPITAL

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Aim. The aim of this study is to audit our outcomes and experience of colonic stent insertion for malignant bowel obstruction.
Methods. Retrospective audit of all stent insertions in a single district general hospital between August 2003 and December 2009. All patients had presented with acute bowel obstruction caused by malignant colorectal disease. Details were collected prospectively and contemporaneously onto a database. Stent insertion was a combined endoscopic and fluoroscopic procedure involving a colorectal surgeon and consultant radiologist.
Results. Stenting was attempted on 62 occasions in 54 patients. The technical success rate was 86% and clinical success rate 84%. The indications for stenting were relief of acute bowel obstruction, palliation and as a bridge to surgery. There were complications in fourteen cases (22.5%) including three perforations and one perioperative mortality. There were three cases of stent migration, six cases of re-stenosis and two stents became impacted with stool. There were no incidents of acute or delayed haemorrhage in any patients.
Conclusion. Our experience shows that stenting for obstructing colorectal cancer is a safe and effective method of alleviating acute and impending bowel obstruction and can be provided safely and effectively in a district general hospital.

0560: ANTEGRADE COLONIC ENEMA IN ADULT PATIENTS: A SINGLE SURGEON SERIES

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Aim: The antegrade colonic enema (ACE) procedure is a minimally invasive treatment for refractory constipation. 47-83% success rates have been reported. The aim of this study is to demonstrate the outcome of patients who underwent the ACE procedure in a district general hospital.
Methods: Retrospective review of all patients who underwent the ACE procedure for refractory constipation between February 2002 and June 2011. Demographic, operative and follow up data were recorded.
Results: A total of 12 female patients had the ACE procedure performed by a single colorectal surgeon. Median age was 43 (24-70) years. Median postoperative hospital stay was 6 (2-17) days. Median follow up was 36 (14-75) months. Conduit stenosis or leakage developed in 4 and 1 patients respectively requiring surgical revision.1 patient developed an incisional hernia with subsequent poor conduit function ultimately managed with an end ileostomy. 2 failed to use the conduit and are now on laxatives. Excluding the latter 3, all patients are managing their constipation without laxatives.
Conclusion: The ACE procedure was successful in 75% of patients who were, thus, able to avoid more aggressive surgery. Patient education and compliance are essential to improve success rates.

0566: CHEAPER DOES NOT NECESSARILY MEAN INFERIOR

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Aim: A recent service change at one of our sites (site 2) saw the sole utilisation of endoscopic equipment from a cheaper manufacturer. Endoscopists favoured the more expensive equipment and thought that service quality may be affected. The objective of our study is therefore to evaluate the effect of change of equipment on service quality.
Methods: Data for 836 colonoscopies performed by three colorectal surgeons on both sites was prospectively collected.
Results: Overall completion rates were 89.9% at site 1 (n=490) and 92.2% at site 2 (n=346) [p=0.182]. Completion rates for each consultant also showed no significant differences.
The overall usage of Midazolam between sites were comparable (3.576mg vs. 3.512mg, p=0.413), however lower doses were observed for two consultants at site 2 (3.23mg vs 2.79mg, p=0.00 and 3.19mg vs 2.95mg, p=0.022). The use of analgesics showed no statistical differences between sites. Comfort score comparison showed no statistical differences overall, however comfort scoring was significantly better at site 2 for two consultants (p=0.03 and p=0.02)
Conclusion: Completion rates, use of sedation and comfort scores are comparable between the sites despite the difference in equipment. Therefore we conclude the quality of service provision is not diminished by the type of equipment utilised.

0586: IS YOUR BLOOD ORDERING SCHEDULE FOR COLORECTAL RESECTIONS UP TO DATE AND COMPLIANT WITH NATIONAL GUIDELINES? AN AUDIT OF CROSS-MATCHED BLOOD UTILISATION IN ELECTIVE COLORECTAL RESECTIONS (ECR)

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Aims: Assess compliancy of our blood ordering schedule against national guidelines by determining cross-matched blood usage in patients undergoing ECR.
Methods: Retrospective data collection for 12 consecutive months, on ECR (benign and malignant). Patients requiring preoperative blood transfusion excluded. Data analysed;operation, pre-operative radiotherapy, preoperative and postoperative haemoglobin, units cross-matched, blood transfusions.